INSURANCE COMPLAINT FORM

Complaint Phone Numbers (608) 266-0103 In Madison
1-800-236-8517 Statewide
Fax Number (608) 264-8115

State of Wisconsin
Office of the Commissioner of Insurance
121 E. Wilson St.
P.O. Box 7873
Madison, WI 53707-7873
oci.wi.gov

The Office of the Commissioner of Insurance assists consumers with their insurance problems. In order for us to investigate your complaint, please complete this form as thoroughly as you can and return it to us at the address shown above. A copy of your complaint will be sent to the company or agent with a request to respond directly to you and to advise our office of the action taken. You should hear from the company or agent in about 25 days from the date you send us your complaint. When we receive the information from the company or agent, we will review the file to determine what action we can take. We will notify you of our determination. If our office is unable to obtain the resolution you desired, you may consider contacting a private attorney for advice. If your complaint involved a claim dispute, you may want to contact your county's small claims court.

TYPE OR PRINT CLEARLY WITH A BLACK PEN. COMPLETE BOTH SIDES OF THIS FORM.

1. Your Name _____

   Street Address _____

   City _____ State _____ Zip Code _____

   Phone number where we can reach you between 8:00 - 4:30 p.m. _____

2. Name of Insurance Company Involved

   _____

   (Please provide the PRECISE NAME of the insurance company. Incorrect names will delay the handling of your complaint. The name of the company can be found on your insurance policy, usually on the first page.)

3. I am filing this complaint as:

   ☐ Insured ☐ Agent ☐ Third-Party
   ☐ Provider ☐ Other (specify) _____

4. Type of Insurance

   ☐ Auto ☐ Individual Acc/Health ☐ Business ☐ Life/Annuity
   ☐ Home ☐ Group Acc/Health ☐ Other (specify) _____

5. Name of Insurance Agent Who Sold the Insurance **(Not the same as 2., above)**

6. Name and Address of Insurance Agency, If Applicable **(Not the same as 2., above)**

7. Name of Policyholder (if other than 1., above)	8. Policy or Certificate #
9. Date Policy or Certificate Was Sold	10. State in Which Policy or Certificate Was Sold
11. Claim or File #, If Applicable	12. Date Loss Occurred or Began, If Applicable

(OVER)

13. Please describe your problem in detail. Attach additional pages, if necessary. Please include **copies** of important papers, letters, or other information, if they relate to your problem.

PLEASE SEND COPIES ONLY—NO ORIGINALS AND NO PHOTOS.

14. Please indicate how you think your problem should be resolved.

15. Have you previously reported this problem to us or any other governmental agency?

☐ Yes ☐ No If yes, state which agency and what action was taken?

Consent to Release Information

The information I have given above is true and accurate to the best of my knowledge and belief. This information may be forwarded to the insurance company and/or agent involved. Any medical information which I have provided, may be shared with the insurance company, if necessary for the investigation of this matter. I understand that under Wisconsin's Open Records Law all information which is in my file, including personal and health information, may become a public record once my file is closed. Only actual medical records which are obtained from a health care provider are confidential under s. 146.82, Wis. Stat.

Signature Date